

No. 2  
1-10-39  
14932

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14932

MAY 13 1940

State File No. 394

Registration District No. 318

Primary Registration District No. 2001

Registrar's No.

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days  
(Specify whether)

In this community 100  
years, months or days

8. (a) PRINT FULL NAME Starkie Vanilla Cavin

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Cavin 6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased May 5 1890  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>149</u>	<u>11</u>	<u>19</u>	hr. _____ min. _____

9. Birthplace Texas  
(City, town or county) (State or foreign country)

10. Usual occupation Cook

11. Industry or business 9

12. Name unknown

13. Birthplace unknown 9  
(City, town or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown  
(City, town or county) (State or foreign country)

16. (a) Informant Leslie Cavin

(b) Address 1114 Sherman

17. (a) Burial (b) Date thereof May 1  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Mem.

18. (a) Signature of funeral director W.P. Campbell

(b) Address 867 Wash. Ave

19. (a) Apr 30 1940 (b) W.E. Haudley MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Green

(c) City or town Springfield  
(If outside city or town limits, write "RURAL")

(d) Street No. 1114 Sherman  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27<sup>th</sup>  
year 1940 hour 1 minute 45 P. M.

21. I hereby certify that I attended the deceased from 4/24/40  
1940, to 4/27/40 1940  
that I last saw her alive on 4/27/40 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Ch. myocarditis - acute 2 day  
essential hypertension  
Due to Post Operative Shock 5 1/2 hr

Other conditions: Essential hypertension  
(Include preceding within 3 months of death)  
Subtotal hysterectomy 4/24/40 40  
Major findings: Fibroid PHYSICIAN  
Of operations: Non-malignant  
Of autopsy: \_\_\_\_\_

Underlines the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
984  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature R.E. Jenkins MD (M. D. or other) 1  
Address 305 College St. Date signed 4/28/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER, FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*W.P. Campbell*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*W.P. Campbell*

Licensed Embalmer No.....

*1747*

P. O. Address.....

*Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

*X*